

NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for
Lupus Medications- LUPKYNIS



Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): up to 30 Days 60 Days 90 Days 120 Days 180 Days 365 Days

Clinical Information

Initial authorization (answer questions 1-12)

1. Does the beneficiary have a diagnosis of active systemic lupus nephritis? Yes No
2. Does the beneficiary have International Society of Nephrology/Renal Pathology Society (ISN/RPS) biopsy-proven active Class III or IV Lupus Nephritis alone or in combination with Class V Lupus Nephritis? Yes No
3. What is the beneficiary's urine protein to creatinine (UPCR) ratio? _____
4. Is the beneficiary age 18 or older? Yes No
5. Does the beneficiary have hypersensitivity to any component of the medication? Yes No
6. Is the medication being administered with strong CYP3A4 inhibitors? (ex. Ketoconazole, itraconazole, clarithromycin)
 Yes No
7. Does the beneficiary have severe hepatic impairment? Yes No
8. Is the beneficiary concomitantly receiving background immunosuppressive therapy? (with the exception of cyclophosphamide)
 Yes No
9. Please list the beneficiary's baseline blood pressure. _____
10. Please list the beneficiary's baseline glomerular filtration rate (eGFR). _____
11. Will renal function (eGFR) be assessed at regular intervals? Yes No
12. Is the medication being prescribed by or in consultation with a rheumatologist? Yes No

For re-authorization (answer questions 13-15)

13. Does the beneficiary continue to meet above criteria? (questions 1-12) Yes No
14. Does the beneficiary show disease improvement and/or stabilization or improvement in the slope of decline? Yes No
15. Has the beneficiary experienced any treatment-restricting adverse effects? (ex. hypertension, neurotoxicities, hyperkalemia)
 Yes No

****Please attach current progress notes documenting disease status and clinical response to the medicine.****

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.